DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/13/10

PRINTED: 11/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING _____ B. WING _____	11/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended 2567 on 11/15/10 to reflect correction of resident #15 (identified in F332) to identify the correct resident #18. During the annual survey conducted from November 1-3, 2010, complaint #TN00025623, was investigated. No deficiencies for the complaint were cited with 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide fingernail care for one (#10) of twenty residents reviewed. The findings included: Resident #10 was admitted to the facility on April 27, 2010, with diagnoses including Alzheimer's Dementia, Osteoarthritis, and General Pain. Medical record review of the Minimum Data Set dated September 15, 2010, revealed the resident had impaired short and long term memory, and required assistance with all activities of daily living.	F 312	F312 CORRECTIVE ACTION: Resident #10 nails were trimmed and cleaned on 11/2/2010. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents' nails were observed for appropriate nail care. Resident's nails will be trimmed weekly. Resident's nails will be cleaned as needed. SYSTEMATIC CHANGES: Nursing staff will be in-serviced by the Staff Development Coordinator or interim Director of Nursing on proper nail care.	12/3/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kate Swafford
TITLE: Executive Director
(X6) DATE: 11/13/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 1 Observation on November 1, 2010, at 1:30 p.m., in the dining room revealed the resident had finished lunch. Continued observation revealed nine fingernails had black debris under the fingernail tips, the right ring fingernail was jagged, the right middle fingernail had a corner broken off, and the left ring fingernail tip had broken off and the remaining nail was jagged and sharp. Observation on November 2, 2010, at 7:30 a.m., and 1:00 p.m., in the dining room and at 10:18 a.m., in the resident's room, revealed nine fingernails had black debris under the fingernail tips, the right ring fingernail was jagged, the right middle fingernail had a corner broken off, and the left ring fingernail tip had broken off and the remaining nail was jagged and sharp. Observation and interview with Licensed Practical Nurse (LPN) #4 on November 2, 2010, at 1:10 p.m., in the dining room revealed resident #10 had nine fingernails with black debris under the fingernail tips, the right ring fingernail was jagged, the right middle fingernail had a corner broken off, and the left ring fingernail tip had broken off and the remaining nail was jagged and sharp. Interview with LPN #4 during the observation confirmed the resident's fingernails were soiled and jagged, requiring cleaning and needed to be trimmed.	F 312	MONITORING: Licensed nurses or designee will do random nail care audits weekly for three months. The Interim DON or designee will report findings to the PI committee monthly for the next 3 months. The PI committee, consisting of Executive Director, DON, Staff Development Coordinator, Medical Director, Pharmacy Consultant, Business Office Manager, Social Services, Health Information Management, Human Resources, Dietary, and Housekeeping/Laundry Director, will review findings and make recommendations according to findings.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility documentation, and interview, the facility failed to provide staff supervision for one (#7) to prevent falls of nineteen residents reviewed. The findings included: Resident #7 was admitted to the facility on April 14, 2009, with diagnoses including Malaise, and Fatigue, Esophageal Reflus, Atrail Fibrillation, Lumbago, Deficiency Anemia, Osteoarthrosis, and Osteoporosis. Medical review of the Minimum Data Set (MDS) dated September 6, 2010, revealed the resident had some difficulty with short term memory, no difficulty with long term memory, and some difficulty with decision making skills. Continued review of the MDS revealed the resident had a history of falls in the last 30 days. Review of the Falls Risk Evaluation dated September 10, and on October 5, revealed the resident, was at risk for falls. Review of the facility provided documentation dated September 10, 2010, revealed, "...CNA (Certified Nursing Assistant) assisted res. (resident) to BSC (bed side commode). Once res. was seated, CNA began assisting roommate to restroom. While assisting roommate, the res. stood up from BSC and then sat in floor in falling motion...recommendations were: Staff stay with res. At all times (res.) is on BSC. Add to	F 323	F323 CORRECTIVE ACTION: Resident #7 has been assessed for falls and intervention initiated. Care guide has been updated with interventions. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents are assessed for falls on admission, quarterly, after significant change and after any falls. Care guides will address interventions and utilized by nursing staff. SYSTEMIC CHANGES: All nursing staff will be in-serviced by Staff Development Coordinator or designee on fall interventions. prevention and daily review of care guides. All falls will be reviewed for effectiveness of interventions and updating of care guides.	12/3/10

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F 323	Continued From page 3 careguide to alert CNA's..." Interview with CNA #1 (the CNA present at the September 10, 2010 fall) on November 3, 2010, at 8:15 a.m., by phone revealed the following: "...I saw the light and went to the room; this resident's roommate wanted to use the (bedside) commode, and this resident (#7) also wanted to use the bed side commode. I place resident #7 on the bed side commode and then placed the resident's roommate on the bed side commode. Then resident #7 started to fall. I had them about two feet apart, and I couldn't turn loose of the resident's roommate to catch resident #7. Continued interview with CNA # 1 revealed the CNA was not aware of the intervention being placed in the careguide as recommended. Review of the facility provided documentation dated October 5, 2010, revealed, "...CNA (Certified Nursing Assistant) assisted res. (resident) to BSC (bedside commode) and instructed not to get up; CNA then assisted roommate . While CNA was assisting roommate, res. attempted to stand & fell over face first onto (the) head. A large hematoma (no size given) appeared within a few seconds ...Sent to ER (emergency room) for evaluation..." Recommendation: "...Staff to stay with pt. (patient) (while on BSC) until (resident) is safe in bed unless family present to assist (resident)." Medical record review of the Resident Transfer Record dated October 9, 2010 revealed the resident was sent to the emergency room due to complaint of "severe headache to left frontal area, and x-ray of left arm (due to) complaint of pain with range of motion." The primary diagnosis was "Fall - HA (headache) Bruising to left eye and	F 323	MONITORING: All falls will be reviewed by Clinical Management Team, which consist of the DON, Staff Development Coordinator, Clinical Manager, Social Services, Activities, Dietary, MDS Coordinator, Rehab Services Manager, and Executive Director. Findings will be reviewed monthly for 3 months by the PI committee, consisting of Executive Director, DON, Staff Development Coordinator, Medical Director, Pharmacy Consultant, Business Office Manager, Social Services, Health Information Management, Human Resources, Dietary, and Housekeeping/Laundry Director, will review findings and make recommendations according to findings.	

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F 323	Continued From page 4 forehead; last few days (resident) is being fed (by the staff. Resident fed self prior to fall)." Medical record review of the CT scan completed on October 10, 2010, revealed the test was negative for recent injuries. (Interview with the nurse consultant on November 3, 2010, at 3:00 p.m., confirmed the x-ray on the arm was not completed at the hospital.) Review of the Witness Interview/Statement Form signed by CNA #2 dated October 5, 2010, revealed, "...I was in (resident's room) assisting patient in bed A. While I was doing that (Resident #7) said he/she needed to use the bathroom so I helped (resident) on the bedside toilet. Then I went to finish assisting (the) roommate. While I was getting (the roommate) shirt on (Resident #7) leaned forward like...was going to stand. I said (resident's name) loud enough for (resident) to hear me. While on my way over to (resident), (resident) fell forward; I rushed out of room yelled for nurse to come to room then went back." Interview with CNA #2 on November 3, 2010, at 8:00 a.m., in the conference room revealed when asked if she was aware of the "Careguide" or that the resident was not to be left alone on the bed side commode, stated she was not aware of the resident's "Careguide" and was not aware of the need to stay with the resident while on the bed side commode. Observation on November 3, 2010, at 4:00 p.m., revealed the resident in the bed, alert and oriented, laying on the back. Interview with the resident at the same time confirmed memory of the fall from the bed side commode, the injury on the forehead, and the pain resulting in a visit to the emergency room for tests (CT scan).	F 323		

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F 323	Continued From page 5 Interview with the Interim Director of Nursing on November 3, 2010, at 2:00 p.m., in the dining room confirmed the facility failed to provide supervision to prevent falls for resident #7.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to administer medications without error for four of forty medication passes observed, resulting in a ten percent error rate. The findings included: Resident #18 was readmitted to the facility on April 30, 2010, with diagnoses including Diabetes Mellitus and Senile Dementia. Medical record review of the physician's order dated October 25, 2010, revealed "1. Give 4 units Novalog (insulin) a (before) breakfast + SS (sliding scale) continue SS ac (before breakfast) ..." Observation on November 2, 2010, at 8:20 a.m., in resident #15's room revealed Licensed Practical Nurse (LPN) #1 administered Novalog 4 units to resident #18. Continued observation revealed the resident had eaten all but a few bites of the scrambled eggs for breakfast.	F 332	F332 CORRECTIVE ACTION: Physician was notified of insulin administration and new orders were given. Physician was notified of multivitamin and Lopid, with new order for multivitamin. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents have the potential to be effected. SYSTEMIC CHANGES: License nurses will be educated on medication pass and the 5 rights by the Interim DON or Staff Development Coordinator. All licensed nursing staff will be in-serviced on insulin administration by the DON or Staff Development Coordinator. Random weekly medication passes will be completed by the Interim DON or designee for 4 weeks and then monthly by the consulting pharmacist or Regional Director of Clinical Services for three months.	12/3/10

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F 332	Continued From page 6 Interview on November 2, 2010, at 8:50 a.m., with LPN #1 outside of resident #18's room confirmed LPN #1 administered to resident #18, 4 units of Novalog insulin after the resident had finished eating the breakfast, and Novalog 4 units was ordered by the physician to be given before the breakfast. Resident #17 was admitted to the facility on September 28, 2010, with diagnoses including Cellulitis (infection of the skin cells), Fatigue, and Diabetes Mellitus. Medical record review of resident #17's physicians order dated September 28, 2010, revealed " ...MVI (multiple vitamin) 1 PO (by mouth) daily ... Lopid (Gemfibrozil) PO AC (before the meal) 600mg (milligrams) BID (two times daily) ..." Observation on November 2, 2010, at 9:15 a.m., in resident #17's room revealed LPN #2 administered one multivitamin with minerals, and one Lopid 600 mg to the resident. Continued observation revealed the resident had consumed approximately 80 % of the breakfast meal. Interview on November 2, 2010, at 10:05 a.m., at the new part nursing station with LPN #2 confirmed LPN #2 administered one multivitamin with minerals and the physician's order stated one multiple vitamin (no minerals), and one Lopid 600 mg after the resident had finished eating the breakfast, and the physician's order stated to administer the Lopid before breakfast. Observation on November 2, 2010, at 7:50 a.m., revealed LPN #5 prepared 20 units of Novolog	F 332	MONITORING: The interim DON or designee will report findings to the PI committee monthly for the next 3 months. The PI committee, consisting of Executive Director, DON, Staff Development Coordinator, Medical Director, Pharmacy Consultant, Business Office Manager, Social Services, Health Information Management, Human Resources, Dietary, and Housekeeping/Laundry Director, will review findings and make recommendations according to findings	

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F 332	Continued From page 7 insulin, for Resident #19 without rolling the vial. When the LPN was preparing to take the insulin to the room, the technique for drawing up the insulin was questioned. When asked if the insulin had been rolled in the hands, the LPN stated, "Are we supposed to?" The surveyor referred the LPN to the instructions on the outer box for the insulin which stated, " ...Roll gently in hands to mix." Continued observation revealed the LPN disposed of the syringe of insulin and prepared another syringe by rolling the insulin before drawing up in the syringe ...Then administered the insulin to resident #19. Interview with the Interim Director of Nursing on November 3, 2010, at 3:00 p.m., in the conference room confirmed the insulin was not prepared according to manufacturer's instructions.	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to store food, store cooking pans, maintain an ice-free freezer, and obtain food temperatures in a sanitary manner.	F 371	F371 CORRECTIVE ACTION: CDM was in-serviced by Executive Director on proper sanitation of food thermometer on 11/02/2010. All dietary staff will be in-serviced on proper sanitation of food thermometer and sealing and dating of food stored in freezer. Freezer was cleaned and ice removed on 11/02/2010. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents have the potential to be affected.	11/26/10

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F 371	Continued From page 8 The findings included: Observation and interview with the Certified Dietary Manager (CDM) November 2, 2010, at 9:30 a.m., to 10:15 a.m., in the facility kitchen revealed: in the meat freezer; one ten pound box of cookie dough ½ full not sealed or dated when opened; eight pieces of fish not sealed or dated when opened; one full ten pound box of pork steaketts not sealed or dated when opened; and four beef fritters not sealed or dated when opened. Observation of the vegetable freezer revealed four two inch piles of ice on the freezer floor. Continued observation revealed the racks the steam table pans were stored on had a buildup of food debris. Observation on November 2, 2010, at 11:08 a.m., to 11:30 a.m., revealed: the CDM removed a pan of white beans from the steamer, obtained a thermometer from a glass of ice water, inserted it into the beans, obtained the temperature and without sanitizing it, returned the thermometer to the glass of ice water; the CDM removed a pan of pureed pork from the steamer and obtained the thermometer from the glass of ice water, and without sanitizing it inserted it into the pureed pork, obtained the temperature, and without sanitizing it, returned the thermometer to the glass of ice water; the CDM was mixing a pan of gravy, without sanitizing the thermometer inserted it into the gravy, obtained the gravy's temperature, and without sanitizing it, returned the thermometer to the glass of ice water. Continued observation at the steam table revealed: the CDM obtained more ice water in the glass; removed the thermometer from the glass of ice water, and without sanitizing the thermometer, inserted it into	F 371	SYSTEMIC CHANGES: Thermometer will be sanitized and cleaned according to policy. Food will be sealed and dated when opened. Maintenance of the ice in freezer will be corrected. MONITORING: The dietary manager will audit correct usage on weekly basis for one month the proper sanitation of food thermometer. The Registered Dictician will observe proper sanitation and temperature taking for tray line monthly for the next 3 months. The dietary manager will audit the dating and sealing of food weekly and monitor for ice in the freezer. The Registered Dictician will observe for dating and sealing of food and ice in the freezer monthly for the next 3 months. The PI committee, consisting of Executive Director, DON, Staff Development Coordinator, Medical Director, Pharmacy Consultant, Business Office Manager, Social Services, Health Information Management, Human Resources, Dietary, and Housekeeping/Laundry Director, will review findings and make recommendations according to findings	

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F 371	Continued From page 9 the cooked pork, obtained the temperature, and without sanitizing the thermometer, returned the thermometer to the glass of ice water; removed the thermometer from the glass of ice water, and without sanitizing the thermometer inserted it into the pureed pork, obtained the temperature, and without sanitizing it, returned the thermometer to the glass of ice water; removed the thermometer from the glass of ice water and without sanitizing the thermometer inserted it into the cooked zucchini, obtained the temperature, and without sanitizing it returned the thermometer to the glass of ice water; removed the thermometer from the glass of ice water, and without sanitizing the thermometer, inserted it into the key lime pie, obtained the temperature, and without sanitizing it, returned the thermometer to the glass of ice water; removed the thermometer from the glass of ice water, without sanitizing the thermometer, inserted it into a carton of whole milk, obtained the temperature, and without sanitizing it returned the thermometer to the glass of ice water. Review of the facility's policy/procedure Proper use and maintenance of a food thermometer revealed, " ...2. Hand wash, rinse and air dry the thermometer before each use ...3. Sanitize the thermometer before each use ...Use alcohol swabs to carefully sanitize the thermometer ..." Interview on November 2, 2010, at 11:30 a.m., in the kitchen with the CDM confirmed the meat products were not stored in a sanitary manner, the vegatable freezer had ice builup on the floor, the rack used to store steam table pans was soiled with debris and not sanitary, the thermometer was not sanitized before each use, and the thermometer was not sanitary.	F 371		